Patient Data

Patient Data for Linking (PII)

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Patient First Given Name		yes	Y	ED, IP, OP	Y	Y	Y	
Patient Second Given Name (midde name)		yes	Y	ED, IP, OP	Y	Y	Y	
Patient Surname (last name)		yes	Y	ED, IP, OP	Y	Y	Y	
Patient Generational Suffix (eg Jr, Sr)		yes	Y	ED, IP, OP	Y	Y	Y	
Patient Address 1		no	Y	ED, IP, OP	Y	Y	Y	
Patient Address 2		no	Y	ED, IP, OP	Y	Y	Y	
Patient City		no	Y	ED, IP, OP	Y	Y	Y	
Patient State		no	Y	ED, IP, OP	Y	Y	Y	
Patient Zip		no	Y	ED, IP, OP	Y	Y	Y	
Patient SSN		no	Y	ED, IP, OP	Y	Y	Y	
Patient Medicare number		no	Y	ED, IP, OP	Y	Y	Y	
Patient's medical record number		no	Y	ED, IP, OP	Y	Y	Y	

Demographics

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Patient Date of Birth		yes	Y	ED, IP, OP	Y	Y	Y	
Patient Sex	Value Set: Administrative Gender (HL7 v3) F/M/U	yes**	Y	ED, IP, OP	Y	Y	Y	
Patient Race	MU requires OMB standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, Oct 30, 1997.	yes**	Y	ED, IP, OP	Y	Y	Y	
Patient Ethnicity	MU requires OMB standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, Oct 30, 1997.	yes**	Y	ED, IP, OP	Y	Y	Y	
Patient Marital Status	Value Set	no	N	ED, IP, OP	Y	Y	Y	
Patient Residence Type	Value Set Patient Residence (Table 148) - need to add concepts	no	N	ED	Y	N	N	

Facility Info

Facility/Setting

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Type of clinic/location where visit	Record must be linked to Facility/Setting and	no	N	OP	N	N	Y	
Has patient been seen in clinic/location before		no	N	OP	N	N	Y	
If yes, how many visits in previous 12 months (excluding this visit)		no	N	OP	N	N	Y	

Care Provider Info

Care Provider Data

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
NPI of physicians		no	N	ED, IP, OP	Y	Y	Y	
Types of care providers seen (including attending, resident, intern, N.P., P. A., consulting, specialist(s), Nurse, mental health providers, social workers)		no	N	ED, IP, OP	Y	Y	Y	
Anesthesia Provider Type		no	N	OP	N	N	Y	
Seen by PCP	Yes/No/Unknown	yes	Y	OP	N	N	Y	
Referral visit	Yes/No/Unknown	no	Y	OP	N	N	Y	

Encounter/Visit Info

Encounter information including dates, priority and point of origin

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Encounter number	Unique identifier of this visit/discharge	no	Y	ED, IP, OP	Y	Y	Y	
Date/Time of admission/visit/arrival	time required when readily available	yes	Y	ED, IP, OP	Y	Y	Y	
Date/Time of provider contact		no	Y	ED	Y	N	N	
Date/Time of departure/discharge	time required when readily available	yes	Y	ED, IP, OP	Y	Y	Y	
Date/Time of admission order		no	N	ED	Y	N	N	
Date/Time bed requested for hospital admission order or transfer		no	N	ED	Y	N	N	
Expected source(s) of payment		no	Y	ED, IP, OP	Y	Y	Y	
Priority of admission	High/Normal/Delayed Priority (IG Table 145)	no	N	IP	N	Y	N	
Was patient triaged?	Yes/No/Unknown/Not Applicable	no	N	ED	Y	N	N	
Triage System	New Value Set defined with LOINC	no	N	ED	Y	N	N	
Triage Level		no	N	ED	Y	N	N	
Mode of arrival	Value Set "Mode of Transport to Hospital" (Table 267)	no	N	ED	Y	N	N	
Point of Origin	Where patient came from before arriving at facility	no	N	ED	Y	N	N	
Is this visit for a new problem, chronic problem (routine or flare-up), preventive care, pre-/post-surgery, surgery/procedure		no	N	OP	N	N	Y	
Initial or follow-up visit?		no	N	ED, OP	Y	N	Y	
Was this patient seen in this ED and discharged in the prior 72 hours?	Yes/No/Unknown	no	N	ED	Y	N	N	
ICU, NICU, or CCU number of days of care		no	N	IP	N	Y	N	

Discharge Info

Discharge information including dates and disposition

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Discharge disposition (Return appointment, Referred, Routine discharge (if surgery), Admitted to ED/hospital, etc.)	See UB-04 for sample IP values, See IG for sample OP values.	no	Y	ED, IP, OP	Y	Y	Y	
Did someone attempt to follow-up with this patient within 24-hours after this surgery	yes/no/unknown	no	N	OP	N	N	Y	
If follow-up attempt was made, what was learned?	answer values are: Unable to reach patient; Patient reported no problems; Patient reported problems and sought medical care; Patient reported problems and was advised by ambulatory surgical staff to seek medical care; Patient reported problems, but no follow-up medical care was needed; Other, Unknown.	no	N	OP	N	N	Y	
If admitted to observation unit, Dates and times (ED discharge, observation unit discharge)		no	N	ED	Y	N	N	
If admitted to hospital, Specialty of admitting physician (e.g. hospitalist)		no	N	ED	Y	N	N	
If admitted to hospital, Type of unit admitted to		no	N	ED	Y	N	N	
If admitted to hospital, Hospital discharge date		no	N	ED	Y	N	N	
If admitted to hospital, Hospital discharge diagnosis		no	N	ED	Y	N	N	
If admitted to hospital, Hospital discharge disposition		no	N	ED	Y	N	N	

Notes and Diagnoses

Clinician Notes

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Clinician notes (e.g., physicians', nurses', P.A.s', N.P.s' and C.N.M.s' notes)	Need to add details of which notes we are seeking: Triage, Intake, HPI, Clinical Impression, Discharge	no	Y	ED, OP	Y	N	Y	

Diagnoses, Reasons for visit, and Problems

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Reason for Visit	For OP overlaps Admission Diagnosis; Single field for MU (less likely to capture multiple reasons).	yes	Y	ED, IP, OP	Y	Y	Y	
Admission diagnosis	For Inpatient: Can get "Reason for Hospitalization."	yes**	Y	IP	N	Y	N	
Diagnoses, including primary and E codes and V codes	There are two separate lists of diagnoses: billing/encounter diagnoses (in ICD-9 now and ICD-10 later) and problem list entries (in SNOMED -CT).	yes**	Y	ED, IP, OP	Y	Y	Y	
Active problems		yes	Y	ED, IP, OP	Y	Y	Y	
Present on Admission (POA) flags for diagnoses	Changed MU setting from "yes" to "no." This would rarely be straightforwad from MU data.	no	N	IP	N	Y	N	

Procedures, Testing and Medications

Diagnostic and therapeutic procedures including surgery and non medication treatments, and results (e.g., lab, imaging, EKG, audiometry, biopsy, physical therapy, speech therapy, or home health care)

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Lab Tests	For each Lab test, please provide the following data elements: 1) Test Name 2) Test Code (e.g. LOINC code) 3) Test DateTime 4)Result DateTime 5) Quantitative Result (with UOM) 6) Qualitative Result	yes**	Y	ED, IP, OP	Y	Y	Y	
Provided or Ordered Diagnostic testing and results (e.g. lab, imaging, EKG, audiometry, biopsy)	Separate items in MU: 1) Diagnostic Tests Pending; 2) Future Scheduled Tests; 3) Laboratory test(s); 4) Laboratory value(s)/result(s); Note that some tests (e.g. biopsy) could be charted as a ***procedure*** (diagnostic procedure), and some procedures are both diagnostic and therapeutic (e.g. D&C).	yes**	Y	ED, IP, OP	Y	Y	Y	
Procedures, Theraputic and/or Diagnostic:	For each Procedure provided or ordered please provide the following data elements: 1) Procedure Name 2) Procedure Code (e.g. SNOMED-CT, CPT) 3) Procedure Ordered DateTime 4) Procedure Start DateTime 5) Procedure End DateTime 6) Procedure Results/Outcome	yes**	Y	ED, IP, OP	Y	Y	Y	
Provided or Ordered Diagnostic and/or Therapeutic procedures, including surgery and non medication treatments (e.g. physical therapy, speech therapy, home health care), including start and end datetime and results	Separate items in MU: 1) Diagnostic Tests Pending; 2) Future Scheduled Tests; 3) Procedures. Note that some procedures (e.g. D&C) could be recorded as a ***diagnostic test***). Ordered Procedures might not be reliably included, if "Procedures" is interpreted in the EHR as "Procedures Performed."	yes**	Y	ED, IP, OP	Y	Y	Y	

Medications and Immunizations								
Data Item	**Comment**	**MU**	**Basic**	**Type of Visit**	**ED**	**IP**	**OP**	**Actual Source**
Medications on admission, during hospital stay and at discharge, please include the following data elements: 1) Medication Name 2) Medication Code (RxNorm) 3) Medication Start DateTime 4) Medication End DateTime	"Medications administered during the Visit" should be readily available through MU data, as is "Medication List." "Medications on Admission" is ***not*** clearly available in MU exports. "Hospital Discharge Medications" should be able to be abstracted from the Discharge Instructions.	yes**	Y	ED, IP, OP	Y	Y	Y	
Type(s) of Anesthesia administered	Required for Out-patient Surgical procedures. Answer value set includes: None, General, Conscious/IV sedation/MAC(Monitored Anesthesia Care), Regional epidural, Regional peripheral nerve, Regional peribulbar, Regional retrobulbar, Regional spinal (subarachnoid), regional other, local/topical, Other.	no	n	OP	N	N	Y	
Immunizations - previous and administered	These are respectively "Immunizations" and "Immunizations Administered during the Visit"	yes**	Y	ED, IP, OP	Y	Y	Y	
Clinical data- Please include the following data elements for each:								
Data Item	**Comment**	**MU**	**Basic**	**Type of Visit**	**ED**	**IP**	**OP**	**Actual Source**
Smoking Status	Per MU, Coded to one of the following SNOMED CT® codes (does not include smokeless tobacco): (1) Current every day smoker. 449868002 (2) Current some day smoker. 428041000124106 (3) Former smoker. 8517006 (4) Never smoker. 266919005 (5) Smoker, current status unknown. 77176002 (6) Unknown if ever smoked. 266927001 (7) Heavy tobacco smoker. 428071000124103 (8) Light tobacco smoker. 428061000124105 (Note: Smoking status should ideally include a date)	yes**	Y	OP	N	N	Y	
Gestation week (if applicable)	Can do with two data elements or include the valid value "not pregnant." It may be preferable to frame as "no pregnancy documented."	no	N	OP	N	N	Y	

Data Item	Comment	MU	Basic	Type of Visit	ED	IP	OP	Actual Source
Patient Asthmatic	Yes/No/Unknown	no	N	OP	N	N	Y	
Asthma Severity	intermittent, mild persistent...severe persistent - only completed if Patient Asthmatic = yes	no	N	OP	N	N	Y	
Asthma Control	well controlled…very poorly controlled - only completed if "Patient Asthmatic?"="yes"	no	N	OP	N	N	Y	
Pain level	0-10 scale	no	N	ED	Y	N	N	
Vital signs on arrival and last taken - most recent height, most recent weight, and blood pressure	Also should record date/time of measurement	yes	Y	ED, IP, OP	Y	Y	Y	
Vital signs on arrival and last taken - pulse, respiratory rate, pulse oximetry		no	Y	ED	Y	N	N	
Temperature on arrival and last taken	temp basic dataset for ED, enhanced for OP	no	Y	ED, OP	Y	N	Y	
Historical Labs	Most recent results and dates blook drawn for the following: Total cholesterol, HDL, LDL, Triglycerides, HbA1c, Blood glucose, Serum creatinine	no	N	OP	N	N	Y	
If injury, cause and intentionality		no	N	ED, OP	Y	N	Y	
Symptoms(s) present during or after surgery/procedure		no	N	OP	N	N	Y	